

Section B: Organizational Data – Master Provider Listing

Use this list to identify your provider type code. Enter the type code in Box 16

- Declare all individual professionals and institutional categories (from the listing below) that are part of this business and subject to the Iowa Medicaid Provider Agreement.
- Attach current certification document(s) as indicated on the list below
- Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.

Type Code	Category	Primary Certification	Additional Certification
1	GENERAL HOSPITAL	CMS certification	License *CLIA
2	PHYSICIAN MD	License	Medicare Enrollment *CLIA
3	PHYSICIAN DO	License	Medicare Enrollment *CLIA
4	DENTIST	License	
5	PODIATRIST	License	Medicare Enrollment
6	OPTOMETRIST	License	Medicare Enrollment
7	OPTICIAN		
8	PHARMACY	License	Medicare Enrollment
9	HOME HEALTH AGENCY	CMS certification	
10	INDEPENDENT LAB	CLIA Certificate	Medicare Enrollment
11	AMBULANCE	License	Medicare Enrollment
12	MEDICAL SUPPLIES	Medicare Enrollment	
13	RURAL HEALTH CLINIC	CMS certification	
14	ESRD	CMS certification	
15	PHYSICAL THERAPIST	License	Medicare Enrollment
16	CHIROPRACTOR	License	Medicare Enrollment
17	AUDIOLOGIST	License	Medicare Enrollment
18	SKILLED NURSING FACILITY	DIA/CMS certification	License
19	REHAB AGENCY	CMS certification	
20	INTERMEDIATE CARE FACILITY	DIA/CMS certification	License
21	COMMUNITY MENTAL HEALTH	Bureau of Community Services	
22	FAMILY PLANNING	Dept Public Hlth approval	
23	RESIDENTIAL CARE FACILITY	License (DIA)	
25	ICF MR STATE	DIA/CMS certification	License
26	MENTAL HOSPITAL	CMS certification	License
27	COMMUNITY BASED ICF/MR	DIA/CMS certification	License
29	PSYCHOLOGIST	License	Medicare Enrollment
30	SCREENING CENTER	Dept Public Health approval	
31	HEARING AID DEALER	License	Medicare Enrollment
32	OCCUPATIONAL THERAPISTS	License	
34	ORTHOPEDIC SHOE DEALER		
35	MATERNAL HEALTH CENTER	DHS Approval	
36	AMBULATORY SURGICAL CENTER	CMS certification	
38	CERTIFIED NURSE MIDWIFE	License	*CLIA
39	BIRTHING CENTER	DHS Approval	
40	AREA EDUCATION AGENCY	IA Dept of Education Agreement	
41	PSYCH MEDICAL INST. CHILDREN (PMIC)	DIA License	
42	CASE MANAGER	DHS Approval	
44	CRNA	License	Medicare Enrollment
45	HOSPICE	CMS certification	*CLIA
48	CLINICAL SOCIAL WORKER	License	Medicare Enrollment
49	FEDERAL QUALIFIED HEALTH CENTER (FQHC)	CMS certification	
50	NURSE PRACTITIONER	License	Medicare Enrollment *CLIA
52	NURSING FACILITY - MENTAL ILL	DIA/CMS certification	License
54	COUNTY RELIEF	DHS Approval	
55	LEAD INVESTIGATION AGENCY	Dept Public Hlth approval	
56	LOCAL EDUCATION AGENCY	IA Dept of Education Agreement	
57	EARLY ACCESS SERVICE COORDINATOR	IA Dept of Education Agreement	
58	PACE	CMS PACE Agreement	
62	BEHAVIORAL HEALTH	License	
63	REMEDIAL SERVICE	Magellan Enrollment welcome letter	
64	HABILITATIVE SERVICES	Applicable certification/accreditation	
67	Assertive Community Treatment (ACT)	License	
71	Health Home	TransformMED self-assessment or NCQA recognition	Health Home Agreement
99	WAIVER	HCBS application required	

PLEASE COPY THIS PAGE AND COMPLETE ONE FOR EACH INDIVIDUAL PROFESSIONAL AND INSTITUTIONAL CATEGORY THAT IS PART OF THIS BUSINESS AND SUBJECT TO THE IOWA MEDICAID PROVIDER AGREEMENT

16. Type Code		17. Licensee or DBA Name		18a. Tax ID (for billing entity)	
19. Requested Effective Date of Enrollment*		18b. Social Security Number		18c. Date of Birth	
20a. Primary Service Address		City		State	Zip
20a1. Primary Address Phone Number		Fax	Email		
20b. Additional Service Address		City		State	Zip
20b1. Additional Service Address Phone Number		Fax	Email		
20c. Additional Service Address*		City		State	Zip
20c1. Additional Service Address Phone Number		Fax	Email		
21. Pay-to Address		City		State	Zip
22. Mailing Address		City		State	Zip
23a. National Provider Identifier (NPI)			23b. Taxonomy Code-(if applicable)		
24a. Primary Professional License or Certification Number – PLEASE ATTACH A COPY OF YOUR LICENSE/CERTIFICATION DOCUMENTS			24b. 10-Digit CLIA Number		24c. State Issued
24d. Initial Effective Date	24e. Current Expiration Date	24f. CLIA Effective Date		24g. CLIA Expiration Date	
25. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.					
26. Primary Specialty* (if applicable)			27. Secondary Specialty* (if applicable)		
28. Has there ever been disciplinary action against this provider's license by a licensing board in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION					
29a. Has the provider ever been sanctioned by Medicare or any state health program? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION					
29b. Has the provider been convicted of a criminal offense related to involvement in any program under, Medicare, Medicaid, or the Title XX services program? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION					
Payment Method Information: EFT is Required when billing under a Federal Tax ID Number. Debit Card is <u>only</u> an option if an individual is doing business under a Social Security Number					
Group Linkage Information* Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:					
30a. Organizational NPI		30b. Organizational Taxonomy		30c. Organization location zip	
Name of Person Completing This Form			Signature of Person Completing This Form		